



# **Rule 132 Modification**

## **Impact: ACT**

Summary of Provider Site Visits

*Final ~ November 27, 2006*

*Parker Dennison & Associates, Ltd.*

SusanPPDA@aol.com  
RustyDPDA@aol.com  
[www.ParkerDennison.com](http://www.ParkerDennison.com)

# Table of Contents

<b>TABLE OF CONTENTS .....</b>	<b>1</b>
<b>SUMMARY OF CONCLUSIONS &amp; ISSUES .....</b>	<b>2</b>
PURPOSE .....	2
CONCLUSIONS & ISSUES .....	2
<b>BACKGROUND .....</b>	<b>5</b>
ABOUT ACT .....	6
<b>METHODOLOGY .....</b>	<b>7</b>
PROGRAM REVIEW .....	7
CLINICAL REVIEW .....	7
FINANCIAL ANALYSIS AND MODELING .....	8
<b>FINDINGS .....</b>	<b>10</b>
STATEWIDE SUMMARY OF FY 06 ACT BILLING .....	10
SITE VISITS .....	10
<i>Program Issues</i> .....	10
<i>Client Record Review Issues</i> .....	12
<i>Fiscal Issues and Modeling</i> .....	13
FY 06 – Financial Findings .....	13
Model Findings .....	14
<b>ATTACHMENTS .....</b>	<b>17</b>
<i>ACT Service Definition Fidelity Review Tool</i> .....	17
<i>CST Service Definition Fidelity Review Tool</i> .....	17

# Summary of Conclusions & Issues

## Purpose

The Department of Human Services/Division of Mental Health (DHS/DMH) requested that in conjunction with Division of Mental Health staff, Parker Dennison and Associates, Ltd. (*Parker Dennison*) assess the consumer service and fiscal impact of proposed modifications to the Rule 132 definition of Assertive Community Treatment (ACT), the introduction of Community Support – Team (CST), and the associated rates for each. DHS/DMH further requested that where feasible, any analytical or review tools developed and used in this process be made available to the larger provider network for their use and planning.

## Conclusions & Issues

All issues summarized below are more fully explained within the body of this report. Based on the review of program, clinical record, fiscal and billing data for 17 existing ACT teams serving approximately 25% of all consumers statewide receiving an ACT service in FY06, *Parker Dennison* believes the analysis suggests the following:

1. At over \$22 million dollars in billing for FY06 (not including psychiatrist or other service billing), DHS/DMH is purchasing a large amount of service activities classified as ACT. However, as evidenced by wide variation in staffing, credentials, service approach, and associated costs, a uniform and consistent service approach is not being provided to consumers statewide.
2. None of the sampled ACT agencies are providing the evidence-based practice of Assertive Community Treatment as delineated by Substance Abuse and Mental Health Services Administration (SAMHSA) or National Association for the Mentally Ill (NAMI). Though variable by team, deficiencies are significant and based on the degree of deviation from the evidence-based practice; it is likely that client outcomes are inferior to those expected by research for ACT programs. Deviations from the evidence-based practice include staff issues such as composition, credentials and supervision; programmatic approach and intensity of service; and match with population for which the service is proven to be most effective.
3. Under the current model and rates for ACT, two out of three providers had considerable net positive margins on ACT. These excess revenues over expenses were used to subsidize other necessary community services that were losing money and largely did not contribute to overall agency net profits.
4. The models and resulting rates proposed by DHS/DMH for ACT and CST appear to be sufficient to cover total provider costs. Actual personnel costs are lower for providers than that modeled by DHS/DMH, and indirect and overhead costs are higher for providers than modeled, the net result is that the rate covers the cost of fidelity to the service definitions. However, this does not address the reduction or loss in net margin used in some cases to subsidize other needed services.
5. Billing productivity for ACT teams sampled was low. Productivity based on paid hours ranged from 30-36% (12-14 hours per 40 paid hours) while the DHS/DMH rate model factored a 43% (17 hours per 40 paid hours) rate. Based on review of consumers and service needs, the 43% productivity rate appears achievable.
6. Crucial recovery-supportive aspects of the evidence-based practice of ACT were largely absent. These included lack of evidence of involvement of peer support, work or education related activities, co-

occurring (MH/SA) goals/interventions, and of family/natural supports involvement. There was a preponderance of reliance on the agency self-fulfilling social and recreational needs for enrolled clients as opposed to efforts to build consumer recovery capacity by supporting linkage to community, family, and natural resources.

7. While substantially meeting level of need guidelines at the time of admission (often years earlier), the client documentation in FY06 suggested that the overwhelming majority of ACT clients sampled had moderate to low levels of need over long periods of time and were being served at corresponding low frequency and intensity of service. This is inconsistent with the population for whom the evidence-based practice of ACT is intended. Often, this circumstance appeared to be the result of an inadequate array of other, less intensive case management and/or other community based alternatives within the provider's contract which would allow for step down with appropriate continuity of service.
8. ACT Residential is being used as a means to improve residential reimbursement but by so doing, is likely increasing perceived compliance risk to agencies and the state. Reclassifying these sites to 24 Hour Supervised or Supported Housing with Community Support services would better reflect the actual services being provided.
9. In their current staffing, service intensity, and approach, the teams sampled overwhelming fit (> 90%) within the requirements of the new service, Community Support – Team (CST). In addition, all consumers and virtually all of the appropriate Rule 132 services those clients were receiving could continue to be delivered within the CST model. This suggests that functionally all teams currently identified as 'ACT' could meet certification requirements to become CST, and that clients need not experience any disruption in service activities.
10. Considerable re-education and monitoring is necessary to insure that ACT billing is appropriate and allowable. This is particularly crucial since approximately 2/3 of consumers receiving an ACT service in FY06 were billed under Medicaid and therefore, potentially subject to federal review.
11. Consistent with findings from other site reviews, clinical record documentation as minimally defined in Rule 132, does not adequately support medical necessity for this level of care (though general Medicaid billing is adequately supported). The overwhelming majority of ACT records reviewed had assessments that were several years old and could not be used to support medical necessity or guide the course of treatment. Functional assessments were not consistent and often were not integrated with service planning. Not only does this increase compliance and audit risk, but does not support focused and appropriate planning and intervention with the consumer. This deficiency is notable in that as a team based service, ACT builds in considerable time for these functions.
12. There are numerous implementation issues identified including:
  - a. Since psychiatrist charges for ACT consumers will now be billed to ACT, and therefore to the DHS/DMH contract allocation, funds from provider's program 350 lines will need to be reallocated to FFS or additional funds will need to be otherwise added to allocations. Previously, psychiatric services for ACT clients were billed directly to HFS and therefore did not count against DHS/DMH contract totals.
  - b. With the net increase in the ACT rate, some existing ACT providers who already are drawing down their full contract allocations will be unable to realize an increase in real revenue to offset increased ACT costs. Contract totals will have to be reviewed to ensure allowance for the increased rates.

- c. Given the substantial gap between current ACT program operations and the proposed definitions, DHS/DMH must ensure that all providers billing the new service of ACT are certified under new guidelines prior to billing ACT.
- d. Agencies report significant vacancies in staffing in current ACT programs. With the new ACT rate being directly calculated on a staffing commiserate with a model with fidelity to the evidence based practice, DHS/DMH should develop a minimum standard of filled staff positions. DHS/DMH should not be billed for an ACT service that has material gaps in staffing.
- e. While initial authorizations for ACT participation appeared to generally meet medical necessity criteria, continued service reviews are not done and medical necessity was frequently not in evidence over a long period of time. DHS/DMH must ensure that a 6-12 month review and reauthorization protocol is established, functional and consistently applied to ensure that the service of ACT is applied to those with the highest need and to ensure appropriate continued recovery support over the long term.

## Background

In early calendar year 2005, a review of the current Rule 132 and Illinois Medicaid State Plan was conducted by the Services Work Group operating under the System Restructuring Initiative (SRI) stakeholders group. The Services Work Group is comprised of consumers, providers, trade associations and their consultant(s), DHS/DMH staff, DCFS staff, HFS staff, and *Parker Dennison* consultants. One finding of the Services Work Group was that to maximize consistency and understanding of requirements, and to minimize perceived compliance risk, the Mental Health Rehabilitation Option portion of the Illinois Medicaid State Plan should be updated, as well as the associated Administrative Rule (Rule 132). To respond to this finding, DHS/DMH requested that *Parker Dennison* facilitate the development of updated service definitions for several services. These definitions were then intended to be used as source documents for the drafting of a Medicaid State Plan Amendment (SPA) and an associated Rule 132 revision.

The Interdepartmental Medicaid Group (IMG), (the collaborative body convened by the Illinois Healthcare and Family Services Department which is comprised of representatives from all Illinois Departments using the Mental Health Rehabilitation Option), requested that the initial priorities for revised service definitions be Assertive Community Treatment, Psychosocial Rehabilitation (PSR), and Community Support. These were chosen primarily as vehicles to replace or augment Activity Therapy, existing ACT, and Therapeutic Behavioral Services, all of which were viewed as most in need of updating. As the Mental Health Authority, DHS/DMH requested that the following objectives be considered during the development process:

- To the extent possible within federal rule or guidance parameters, service definition language and activities should expressly support recovery and resilience.
- Where recognized evidence based and/or research supported practices were identified, these should be used to guide new service definition development.
- New definitions should result in continued availability of services and interventions needed by consumers (though it is recognized that what a service is called may change).

Working with the Services Work Group, *Parker Dennison* facilitated the development of new definitions for ACT, PSR, and four modalities of Community Support (Individual, Group, Team, and Residential). The development process involved collecting definitions for similar services from other states, reviewing recent federal CMS actions, and reviewing evidence based practice tool kits and/or research. From these, drafts were prepared by *Parker Dennison* for review, discussion and modification by the service specific subgroups. Once drafts were finalized by these subgroups, the full Services Work Group reviewed and ultimately approved the definitions which were then sent simultaneously to the Interdepartmental Medicaid Group and SRI. Both of these groups provided comment and the final service definition was ultimately approved by HFS as the Medicaid Authority based on a recommendation from DHS/DMH and the IMG.

Using the final draft service definitions, DHS/DMH prepared a model to set draft rates for the new services. This model included assumptions about salaries, benefits, productivity and indirect costs. A consistent methodology was used for each new service and this methodology is incorporated in and consistent with the methodology approved in the Illinois Medicaid State Plan.

Since DHS/DMH requested that evidence based practices be utilized where possible, ACT, as one of six recognized evidence based practices, was modeled substantially consistent with these guidelines. Hypothesizing that under current Illinois rules and funding, ACT was largely not being delivered consistent with

the evidence based practice, the service definition of Community Support – Team (CST) was created to ensure an achievable vehicle for continued intensive team based interventions and supports.

*Parker Dennison* was asked to assess the consumer service and fiscal impact of proposed modifications to the Rule 132 definition of Assertive Community Treatment (ACT), the introduction of Community Support – Team (CST), and the associated rates for each.

## About ACT

The United States Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the President's New Freedom Commission Report view Assertive Community Treatment as one of six currently recognized evidence based practices for mental health. ACT is a service delivery model that uses a trans-disciplinary team, including a psychiatrist, nurses, counselors, recovery support specialists, and vocational specialists, to actively outreach and engage and serve those individuals who have not been successful in their recovery using traditional service delivery methods. The teams are characterized by low case loads, frequent coordination and communication among themselves and with the client, clear professional clinical leadership and supervision, primary service delivery in vivo with the client, and ability to serve medical and substance abuse symptomology co-occurring with the client's primary mental illness. Research summarized by SAMHSA indicates that ACT is NOT an evidence based practice for all mental health clients but rather is effective with clients who are highest need, most difficult to engage, unable to consistently avail themselves of traditional rehab supports/services, most frequently hospitalized, and typically within a narrow range of a diagnostic profile.

Based on research, SAMHSA has sponsored the creation of comprehensive guidelines ('tool kit') specifying the team composition, program components, target population, and service activities that are linked to superior and evidence supported outcomes. The research from SAMHSA further indicates that *"programs that adhere most closely to the evidence based practice of ACT as described in the tool kits are more likely to get the best outcomes"*<sup>1</sup>.

---

<sup>1</sup> More information on the ACT tool kit may be found on the SAMHSA website at:  
<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

# Methodology

Representing rural, suburban, and urban areas, DHS/DMH selected three current ACT providers for site visits and analysis. The three providers were:

- **Provider A** (south-rural): 1 team, approximately 41 clients, including ACT Residential
- **Provider B** (north—suburban): 1.5 teams, approximately 80 clients
- **Provider C** (north—urban/suburban): 15 teams, approximately 658 clients, including deaf/hard of hearing specialty teams

The total ACT consumers served by these three agencies represents approximately 25% of all consumers statewide provided an ACT service in FY06.

Site visit teams included two *Parker Dennison* consultants (one fiscal and one program), two DMH Central Office staff, and two DMH Regional staff for each provider. Site visit teams spent between 1.5 and 2.5 days at each site visit representing a range of 72-120 person hours per site. In addition, each provider actively participated in the analysis process typically including their CEO, Clinical Director, ACT Program Director, CFO/Finance Director, and Billing/Business Office Staff.

## Program Review

Using the final draft ACT and CST service definitions, service definition fidelity tools were developed to measure current program and clinical practice (as evidenced by clinical record documentation) to proposed standards (Attachment 1). Each tool is divided into two sections: a program review portion which looks at specific program requirements such as staffing, credentials, hours of operation, etc; and a second section which measures evidence of specific clinical practices. Since the tools measure current practices (FY06) to proposed standards to which the provider is not currently required to comply, the results suggest the gap between current practice and proposed practice rather than the 'quality' or compliance with current requirements for ACT.

The program review portion of the service definition fidelity tools generally were reviewed through group discussion with the provider Clinical Director and ACT Program Director(s) with direct verification of some policies and practices by the consulting team. In all cases, provider agencies had reviewed the ACT and CST service definitions and associated definition fidelity tools in advance. Final scoring of all program areas of the definition fidelity tools were discussed among the full review team, including agency representatives, and results reflect consensus of the both the team and the agency.

## Clinical Review

Clinical review of ACT clients was measured in three ways: record reviews, aggregate billing data analysis, and review of functional assessment scores.

**Record Reviews**—chart reviews of clients receiving ACT services during FY06 were conducted at each provider agency. The sample was selected by the agency and was as follows:

- Provider A – 10 records representing 25% of total ACT clients
- Provider B – 23 records representing 30% of total ACT clients
- Provider C – 75 records (no less than 3 records from each of the 15 ACT teams) representing 11% of total ACT clients

**Aggregate Billing Data Analysis**—using the providers' own billing data, various reports and analysis was conducted for all ACT billing in FY06. From this aggregate analysis, clinical service patterns could be discerned and summarized including:

- Frequency of consumer contact
- Location of services delivered (office versus community locations)
- Amount of service provided by service type
- Amount of psychiatric services
- Multi-team member involvement
- Amount of billing involving direct client contact versus collateral or team process

Since these data represented ALL ACT clients for FY06, the patterns served as a validity check for the findings resulting from the detailed client records reviews.

**Functional Assessment Scores**—each site visit agency was asked to provide a summary of functional assessment scores for ACT clients where they were able. Two agencies, Provider A and Provider B, used the Level of Care Utilization Scale (LOCUS) with a large sample of their current ACT clients. The third agency, Provider C, provided access to GAF and Multnomah scores in the records reviewed. While these functional assessment scores were not directly verified in all cases (i.e., detailed review of each domain score and supportive documentation), consulting team members conducting chart reviews did look for general consistency with the aggregate functional assessment score and evidence in the client's record.

## Financial Analysis and Modeling

Aggregate ACT billing information for the entire FY06 was summarized from each provider agency's information system. All fiscal analysis used provider agency data to minimize perceived discrepancies or reconciliation issues with state data. From these data, there were three primary products produced:

- A pro forma summarizing the provider agency's direct and indirect ACT costs and revenues for FY06. Billing levels were computed using the rate schedules, including the 1/1/06 rate increase. ACT FY06 performance was summarized showing results as if fee for service at 1/1/06 rates was in place for ACT for the year compared to the existing DMH grant structures.
- Using FY06 ACT units, draft ACT and CST rates and the new definitions, a similar pro forma was prepared for the first year of the new services
- Provider agency cost data were used in the DMH rate model to compare a rate derived from their actual costs to the one proposed by DMH.

Once the various financial models were completed, they were presented to the entire consulting team and provider agency leadership for review, discussion and concurrence. Provider agency financial staff were then given several days to review the models and findings in detail. Each agency indicated their material concurrence with the final analysis and modeling.

# Findings

## Statewide Summary of FY 06 ACT Billing

The following key statistics were drawn from a report titled: *FY2006 YTD Medicaid and Non-Medicaid Billing Status Report – Statewide by Program*, which was run on October 23, 2006 from the DHS/DMH MIS production file:

- Accepted **TOTAL ACT** billing - \$22,087,445
  - Does not include billing for psychiatrist, PSR (TBS group/individ, skills training), counseling, and other services provided to ACT enrolled consumers outside of the ACT program. Based on site visit samples, this is likely to add up to 30% or a GRAND TOTAL billing for ACT consumers of approximately \$28,000,000.
- Accepted **ACT Residential** billing - \$3,435,061
- **Unduplicated clients** received an ACT service – 3294
  - Approximately 2/3 of clients receiving an ACT service were enrolled in Medicaid.
- Clients receiving an ACT service who did not meet **Target Population** definition – 300
- **Hours of service** per client receiving an ACT service (does not include psychiatrist or any other service billed outside of ACT 90 series billing codes):
  - All clients – 1.45 hours per week
  - Medicaid enrolled clients – 1.5 hours per week
  - Non-Medicaid clients - .73 hours per week

## Site Visits

The following summarizes the patterns of findings found from the site visits, chart reviews, and provider-specific data analysis. The issues listed below are deemed most important to fidelity to the ACT and/or CST service definition and associated rates, and represent significant patterns across teams and agencies. ***It must be noted that not all issues apply to each team or each agency.*** Summary reports of each site visit were provided to each agency detailing their specific issues.

### Program Issues

Each agency's current ACT program structure, staffing and approach was compared to the proposed ACT and CST service definition requirements using draft ACT and CST Service Definition Fidelity tools. Frequent issues found included:

- Though it varies somewhat by team, the site visit agencies' approach to ACT is substantially not consistent with evidence based practice for ACT Teams as recognized by SAMHSA (see

<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>) or NAMI (see [http://www.nami.org/Template.cfm?Section=ACT-TA\\_Center](http://www.nami.org/Template.cfm?Section=ACT-TA_Center)). Frequent areas of discrepancy include:

- Team composition—lack of nursing staff, low psychiatric involvement, lack of vocational resources, lack of peer specialist/recovery specialists, lack of advance credentialed team leads, and little or no administrative support
  - Nursing and psychiatric services are largely not integrated with the team and function similarly to any other outpatient nursing/psychiatric appointment
  - Low level of consumer contact (low frequency and high percentage of non-direct service)
  - High reliance on group services, most of which are not curriculum based
    - Provider B ACT team group activities were strongly curriculum based
  - Minimal evidence of development and involvement of family and natural supports
  - Preponderance of self-fulfilling social, recreational, and most service provision within an agency setting rather than through natural supports or other community linkages
  - No primary team coverage of crisis 24/7
  - Most coverage was Monday – Friday, 8 AM – 5 PM with telephone coverage via pager
  - Minimal crisis billing which would typically be inconsistent with acuity of targeted consumers
- Frequency of consumer contacts per week varied by team but ranged from under 1 contact per week to just over three contacts per week (not including ACT residential).
- Some teams had nearly one-third of their ACT contacts in the form of groups, most of which were social or recreational.
  - For most teams, between one-third to one-half of billed units did not directly involve the consumer
- Only one team reviewed met the minimum threshold of 75% of services being delivered in the community (natural setting). The SAMHSA evidence base practice of ACT recommends 80%. Percentages of service delivered in the community average in the mid-60s% and ranged from just under 50% to the low 70s%. It is hypothesized that these percentages are negatively affected by services being delivered in settings required to be certified under current Rule 132 definitions and by ACT Residential which by design is not a community based service.
- Proposed ACT Service Definition Program Review scores ranging from approximately 36% to 65% and on average would have scored slightly more than 50%. Areas of deficits were significant and centered primarily on staffing, service delivery, and team functions. Frequent areas NOT MET included:
- At least 6 FTEs plus a psychiatrist and full time program assistant
  - Full-time team leader who is a licensed clinician
  - Full-time RN
  - Program assistant
  - One team member trained in recovery/peer specialist
    - Most teams received some training in recovery principles. However, there is very limited involvement of recovery specialists or individuals who self disclose prior personal treatment experience.
  - 75% of team contacts outside of office
  - Primary 24/7 crisis coverage by ACT team
  - One staff member trained in rehabilitation/vocational areas
  - Minimum of three contacts per week
  - Groups are curriculum driven and have eight or fewer participants and do not comprise more than two hours per participant per week.

- ACT Residential, as delivered by the one agency reviewed who offered it, essentially functioned as a group home with the ACT service being billed by residential staff for activities primarily within the residence. These services were overwhelmingly similar to Therapeutic Behavioral Health services billed by other residential providers, but by billing ACT, a higher rate was charged. There was substantially no difference in client acuity, staffing credential, or therapeutic intervention to clients in this residence than that found in most 24 Hour Supervised Residential sites. The agency reports historical regional DMH support for this structure and billing as a means to support development of residential services, and similar ACT residential programs may exist elsewhere in the state.
- Overall, all ACT teams reviewed scored above 90% for Program Review when compared to the proposed Community Support Team definition requirements. The only significant area of deficit was the lack of full time licensed team leaders.
- The approach to ACT as evidenced in the overwhelming majority of the teams reviewed would be consistent with the allowed service combinations in the proposed definition for Community Support Team. These service combinations included the practice of having ACT members participate in PSR, extensive use of groups, minimal use of psychiatry, and providing services in some certified sites.

### Client Record Review Issues

Approximately 110 records of consumers enrolled in ACT at the three agencies were reviewed using the draft ACT Service Definition Fidelity tool. Patterns of issues included:

- Though variable by team, ACT teams (excluding physicians) reviewed billed an average of just over 1.3 hours per client per week (approximately 5 units). Of these, approximately a third are billed units for internal or collaborative activities that do not directly involve a contact with the consumer.
- Physicians who bill through agencies and are serving ACT clients billed on average 1 unit or less per ACT client per month.
  - It is notable that some ACT consumers had no billing for psychiatric services. Though some (not all) of this may be accounted by ACT consumers receiving psychiatric services through Community Health Centers, little or no coordination between the physician and the ACT team was evident in the records.
- Frequent billing and associated documentation was found for activities that would not be Medicaid Rehabilitation Option allowable. These included:
  - Billing ACT for the banking tasks/admin tasks related to Representative Payee services where the consumer was not involved.
  - Billing ACT for door to door traveling time to take consumers goods, medications, and other delivery tasks where the consumer was not involved.
  - Extensive billings for transportation, with and without consumers, to procure goods, attend appointments, and to meetings where the notes did not reflect a therapeutic activity focused on an assessed need was occurring.
  - Treatment plan objectives that were directly contradicted on assessments/functional tools, and treatment goals that were achieved for some time but no change in service noted.
- Review of clinical records found that the substantial majority of the ACT enrolled consumers would have met the proposed ACT admission criteria at the time of admission. However, for 16 out of the 17 teams reviewed, only about 20-25% of ACT enrolled consumers were found to show evidence of documentation meeting admission criteria at the time of review. The current ACT definition and standards do not contain specific requirements that consumer eligibility be reviewed on a regular basis.

- Examples of reasons why the consumer were judged as not meeting criteria included:
    - Consumer had stable and appropriate housing for more than one year
    - Consumer had family providing direct support, including maintenance of housing for more than one year
    - Consumer participating consistently for more than a year in traditional community based services such as PSR and/or Outpatient with infrequent (less than 1 time per week) contact
    - Annual functional assessments indicating no deficits or limited needs and/or having met original discharge goals.
    - Long periods of stability (> than 1 year) and low intensity of service.
    - Consumer did not meet broad definition of Target Population
  - As a notable exception to the above, over 70% of Provider B's ACT enrolled consumers met admission criteria at the time of review indicating an overall very high level of acuity and appeared to be functioning as clear alternative to long term hospitalization for many of their ACT consumers.
- ➔ Consumer records review results from the proposed ACT Service Definition Fidelity tool included:
- Areas where more than 50% of the records reviewed met criteria included:
    - Evidence of current treatment plan
    - Services inclusive of medication related interventions
    - Evidence of environmental and other support services
    - Evidence of ongoing symptom assessment and management
    - ACT ordered on the treatment plan
    - More than one team member providing services
    - Evidence of consumer involvement in treatment planning
    - Evidence of services for social development
  - Areas where 50% or fewer of the records reviewed met criteria included:
    - Comprehensive assessment completed within 30 days of admission
    - Continuing care, transition, and/or discharge planning goals present
    - Evidence of involvement of peer support
    - Work or education service activities present
    - Co-occurring (MH/SA) goals present
    - Evidence of primary crisis coverage by ACT Team
    - Evidence of family and other natural supports involvement
    - Evidence of treatment goals/objectives modified for consumer's current needs/functioning level
    - Individualized treatment goals and objectives

### Fiscal Issues and Modeling

Agency actual FY06 financial information for ACT services was reviewed to determine direct and indirect costs. FY06 actual billing levels were computed using the rate schedules, including the 1/1/06 rate increase. ACT FY06 performance was summarized showing results as if fee for service was in place for ACT for the year. Billing data was used to calculate average staff billable time per week, and average weekly/monthly hours of individual service per staff member and per physician.

#### FY 06 – Financial Findings

The financial analysis generated the following key findings ACT regarding FY 06 financial and billing performance:

- ➔ FY 06 actual **costs per ACT team** (not at new definition fidelity) are as follows:

- Provider A - \$434,000<sup>2</sup>
  - Provider B - \$365,000
  - Provider C - \$400,000 (average across 15 teams)
- ➔ Agency FY 06 **net margins** on ACT services based on existing productivity rates (not at new definition fidelity) were:
- Provider A - \$260,000
  - Provider B - \$170,000
  - Provider C – (-\$600,000)
- ➔ FY 06 **productivity** as measured by *billed time divided by paid time*:
- Provider A – 33%<sup>3</sup>
  - Provider B – 31%
  - Provider C – 36% (average across 15 teams)

#### Model Findings

Models were developed to calculate the change in billing revenues upon conversion to the revised Rule 132 definitions for ACT and Community Support Team (CST) and to test the validity of the proposed DMH rate models.

- ➔ **Impact on billing levels** from converting a portion of existing ACT consumers to a combination of the new definitions for ACT and CST was modeled assuming that FY06 ACT units would split between new ACT and CST. Preliminary rates supplied by DMH for the purpose of these site visits were used for the new services. The financial impact varies depending on the portion of the existing ACT members that meet criteria for the revised ACT definition. The following reflects the net change in billing using the agency agreed upon percentage of ACT consumers who meet the new ACT service definition (percentage assumptions noted in [brackets]). The balance of the consumers were assumed to meet the new CST definition.
- Provider B - \$123,497 [70% conversion rate]
  - Provider C - \$178,000 [25% conversion rate]
  - Provider A's impact is more challenging to analyze because only 30%<sup>4</sup> of its existing ACT consumers were found to be eligible for the new ACT definition and Provider A was only serving 41 ACT consumers in FY06. Even if a more generous 50% of Provider A's current ACT clients were found to be eligible for new ACT, the new ACT team would only have approximately 20 clients, which would result in a loss of \$85,000 on ACT services alone. Since it did not appear feasible for Provider A to have an ACT team with so few eligible clients, Provider A's financial impact was also modeled for conversion of all existing ACT services into CST. Conversion of all ACT clients into CST should allow the overall service level to be maintained for consumers since those consumers with greater acuity can receive more CST services. Conversion of all ACT into CST results in reduced revenues for Provider A of

<sup>2</sup> Approximate. Reflects 24 hour staffing for one team (ACT Residential). Subtracts the room and board costs from ACT Residential for one team.

<sup>3</sup> Approximate. Group billing time is not incorporated in this percentage.

<sup>4</sup> The clinical judgment of Provider A staff was that a maximum of 10 – 15 consumers will be clinically eligible for ACT, and a full ACT team is 50 clients.

approximately \$72,000 compared to projected FY06 ACT fee for service billings. However, the existing structure of a group of staff who are delivering both CST or ACT services and residential services must be modified to achieve fidelity to ACT or CST. Provider A's impact was negative due to two factors. The preliminary CST rate is \$9 less per hour than the prior ACT rate because the number/credentials for staff required for CST is less than the old ACT service definitions requirements. The second contributing factor is that Provider A, as a small rural provider, will not have sufficient consumers who meet the new ACT definition to form an ACT team. Therefore, the negative impact from the lower CST rate is not offset by the increase in the preliminary ACT rate compared to the rate under the old service definition (increase of \$30/hour) as it is for other providers who have sufficient eligible consumers to offer both ACT and CST under the new definitions.

- **Changes in costs** associated with achieving fidelity to the new ACT definition were not modeled, and could be supported, at least in part, with the billing increases projected for the two providers who will have sufficient consumers to support at least one ACT Team. Cost adjustments were not modeled because each provider must determine how it will restructure its services in general under the revised Rule 132, and specifically how it will reach ACT and CST team compositions that meet fidelity. For example, in one provider, nursing staff could be reallocated from existing ACT teams to the new ACT teams while still meeting the requirements for CST, since CST does not require nursing. Developing all of the assumptions for adjusting service mix and reallocating staff as a part of implementing the revised Rule 132 was beyond the scope of these site visits.
- **Indirect and overhead expenses** (including general clinical leadership, quality, information systems, training, and other general and management expenses) as a percentage of direct personnel costs for each ACT team<sup>5</sup> was modeled by the state at 45%. Actual percentages by agency were substantially higher. Due to variances in how each agency classifies indirect program costs and overhead, consistent methods for distinguishing between indirect and overhead rates were not feasible. Also, agency costs were not reviewed for appropriateness or reasonableness of costs or allocation methods.
  - Provider A – 78.8%
  - Provider B – 69%
  - Provider C – 64%
- **Staff salaries and benefits** used in the state rate model were generally *above* actual combined salary and benefit costs at the agencies. Each agency's percentage below state modeled salary and benefit costs is listed below. Benefit percentage listed in [brackets—state modeled at 23%].
  - Provider A – salaries/benefits 47% less than state modeled [15.95% benefits]
  - Provider B – salaries/benefits 17.7% less than state modeled [25% benefits]
  - Provider C – salaries/benefits 7.6% less than state modeled [25% benefits]
- **Testing of the ACT rate** model proposed by the state found that the methodology and assumptions used by the state yielded a rate generally at, or higher than the agency-specific rate using the agency's actual cost data.

Agency	Onsite Rate (per hour)	Offsite Rate (per hour)	Weighted Average Rate (per hour)

---

<sup>5</sup> Other case management or residential expenses are excluded from cost centers that combine ACT costs with other services

<b>State Modeled Rate</b>	\$69.98	\$117.45	\$110.97
<b>Provider A</b>	\$74.73	\$86.68	\$81.90 (26.2% lower)
<b>Provider B</b>	\$97.05	\$112.57	\$106.36 (4.1% lower)
<b>Provider C</b>	\$105.80	\$122.73	\$115.96 <sup>6</sup> (4.5% higher)

- **Testing of the CST rate** model proposed by the state found that the methodology and assumptions used by the state yielded a rate generally at, or higher than the agency-specific rate using the agency's actual cost data.

<b>Agency</b>	<b>Onsite Rate (per hour)</b>	<b>Offsite Rate (per hour)</b>	<b>Weighted Average Rate (per hour)</b>
<b>State Modeled Rate</b>	\$42.68	\$77.32	\$73.05
<b>Provider A</b>	\$51.79	\$60.08	\$56.77 (22.3% lower)
<b>Provider B</b>	\$63.19	\$73.31	\$69.26 (5.2% lower)
<b>Provider C</b>	\$70.10	\$81.31	\$76.83 (5.2% higher)

<sup>6</sup> It is notable in both of the rate models (CST/ACT) that salaries used by DMH for rate calculation are higher than those actually paid by the agency and offset higher indirect and overhead costs for agencies compared with the state model. The number of managers at Provider C that did not provide direct service appears to be a major contributing factor in its costs being greater than the DMH models or that of the other two providers.

# Attachments

**ACT Service Definition Fidelity Review Tool**  
**CST Service Definition Fidelity Review Tool**

**ACT Provider:**

**Team Name (if more than 1):**

**PART A: INDIVIDUAL RECORDS AUDIT**

Page \_\_\_\_ of \_\_\_\_

	#	#	#	#	#
	Date Span:				
<b>1. Service Planning/Tx Plan</b>					
1.1. Current Comprehensive Assessment completed by ACT team.	Yes No Yes But				
• Psychiatric History, Mental Status & Diagnosis	Yes No Yes But				
• Physical Health	Yes No Yes But				
• Use of Drugs & Alcohol	Yes No Yes But				
• Education & Employment	Yes No Yes But				
• Social Development & Functioning	Yes No Yes But				
• Activities of Daily Living	Yes No Yes But				
• Family Structure & Relationships	Yes No Yes But				
1.2. Each part of comprehensive assessment completed with consumer by team member with skill and knowledge in the area being assessed.	Yes No Yes But				
1.3. Comprehensive assessment initiated AND completed within 30 days of admission to ACT team.	Yes No Yes But				
1.4. Current Treatment Plan in Chart Based on Comprehensive Assessment	Yes No Yes But				
1.5. ACT Service Ordered on Treatment Plan	Yes No Yes But				
1.6. Evidence of goals & objectives reviewed and modified to match current functioning of consumer	Yes No Yes But				
1.7. Goals & objectives in chart individualized for this consumer	Yes No Yes But				
1.8. Evidence of consumer participation in planning & evaluating goals & objectives.	Yes No Yes But				
<b>2. Availability &amp; Engagement</b>					
2.1. Evidence of 24/7 coverage	Yes No Yes But				
2.2. Minimum of 4 contacts/month	Yes No Yes But				
2.3. Persistent in engagement: at least 2 f-t-f attempted contacts per week	Yes No Yes But				
2.4. ACT team provides crisis coverage	Yes No Yes But				
2.5. Evidence that service frequency aligns with individual consumer needs	Yes No Yes But				
<b>3. Team Functioning</b>					
3.1. Evidence that more than one team member involved with client	Yes No Yes But				
3.2. Evidence of primary ACT team member for each client	Yes No Yes But				
3.3. Notes reflecting evidence of team meeting decisions	Yes No Yes But				

	# Date Span:				
<b>4. Services</b>					
4.1. Notes reflect covered ACT activities	Yes No Yes But				
4.2. Group billing limited to curriculum-based therapeutic, offered only to ACT members, no more than 8 participants, and no more than 2 hours per week.	Yes No Yes But				
4.3. Services are offered individually with exception of 4.2 OR occasional 1 staff member to 2 consumers with compatible goals.	Yes No Yes But				
4.4. Evidence that all ACT team members assess mental health symptoms in response to medication and medication side effects.	Yes No Yes But				
4.5. Evidence of Symptom Assessment & Management, including ongoing assessment, psychoeducation, and symptom management efforts.	Yes No Yes But				
4.6. Evidence of supportive counseling and psychotherapy on planned and as-needed basis	Yes No Yes But				
4.7. Evidence of Medication prescription, administration, monitoring, and documentation	Yes No Yes But				
4.8. Evidence of dual diagnosis substance abuse services (assessment & intervention)	Yes No Yes But				
4.9. Evidence of work-and education-related services	Yes No Yes But				
4.10. Evidence of support to activities of daily living	Yes No Yes But				
4.11. Evidence of social/interpersonal relationship and leisure time skill building	Yes No Yes But				
4.12. Evidence of Peer Support services	Yes No Yes But				
4.13. Evidence of environmental and other support services	Yes No Yes But				
4.14. Evidence of services offered to families and/or other major supports (with permission)	Yes No Yes But				
<b>5. Discharge/Transition Planning</b>					
5.1. Evidence of discharge/transition goals and planning (including titration of service)	Yes No Yes But				
5.2. ACT is only offered with Inpatient, Crisis residential, Crisis respite, Residential, SASS, or outpatient services during defined transition periods (either into or out of ACT services) that are included on treatment plan and DHS-authorized.	Yes No Yes But				
<b>RECORD REVIEW TOTALS</b>					
<b>Record Review Score:</b>				<b>Reviewer</b>	

***Provider:***

***Site:***

***PART A: Record Review Notes:***

***Reviewer:***

1. Staffing			
1.1. Core Staff of Team Includes:			
• At least 6 FTEs + psychiatrist & program assistant	Yes	No	Yes But
• Full-time team leader who is licensed clinician	Yes	No	Yes But
• Psychiatrist with minimum of 10 hours per week for every 50 individuals on team. (APRN can substitute for up to half of the psychiatrist time.)	Yes	No	Yes But
• Full-time RN (for first 2 years, existing ACT teams may use LPN; new teams must use RN)	Yes	No	Yes But
• Program/administrative assistant	Yes	No	Yes But
• 1 member have special training in recovery; ideally be a Certified Recovery Support Specialist	Yes	No	Yes But
• One member have special training in rehabilitation counseling	Yes	No	Yes But
• One member of the team must have special training and certification in substance abuse treatment and/or treating persons with co-occurring disorders	Yes	No	Yes But
1.2. Staff ratio is 1 FTE for each 10 consumers (excluding psychiatrist and program assistant)	Yes	No	Yes But
1.3. Team reflects the language, culture, and ethnicity of the population being served.	Yes	No	Yes But
2. Capacity			
2.1. 75% of all team contacts (across all consumers) occur outside of the office	Yes	No	Yes But
2.2. On average, consumers receive at least 3 contacts per week	Yes	No	Yes But
2.3. Minimal unplanned dropouts and involuntary closures.	Yes	No	Yes But
2.4. Staff schedules or other documentation reflect 24/7 crisis response availability including emergency psychiatric coverage.	Yes	No	Yes But
2.5. Evidence that consumers who refuse treatment receive continuing attempts to engage them for at least 3 months.	Yes	No	Yes But
3. Team Functioning			
3.1. Regular, scheduled and conducted organizational team meetings	Yes	No	Yes But
3.2. Evidence of daily assignment schedules	Yes	No	Yes But
3.3. Team meeting minutes	Yes	No	Yes But
4. Operations			
4.1. Evidence of Medication policies and procedures	Yes	No	Yes But
<b>PROGRAM REVIEW TOTALS</b>			
<b>GRAND TOTAL (Record + Program)</b>			

**Provider:**

**Team:**

**PART B NOTES:**

**Reviewer:**

**NOTES:**

.

1. Scoring is 10 points for yes, 5 for yes but, and 0 for no
2. Recommend looking only at current treatment plan period with exception of comparing to see if treatment plans vary over time.

CST Provider:

Team Name (if more than 1):

PART A: INDIVIDUAL RECORDS AUDIT

Page \_\_\_\_ of \_\_\_\_

	# Date Span:				
<b>1. Service Planning/Tx Plan</b>					
1.1. Current Comprehensive Assessment included in chart.	Yes No Yes But				
1.2. Current Treatment Plan in Chart Based on Comprehensive Assessment	Yes No Yes But				
1.3. CST Service Ordered on Treatment Plan	Yes No Yes But				
1.4. Documentation that the consumer meets CST admission criteria	Yes No Yes But				
1.5. Evidence of goals & objectives reviewed and modified to match current functioning of consumer	Yes No Yes But				
1.6. Goals & objectives in chart individualized for this consumer	Yes No Yes But				
1.7. Evidence of consumer participation in planning & evaluating goals & objectives.	Yes No Yes But				
<b>2. Availability &amp; Engagement</b>					
2.1. Evidence of 24/7 coverage	Yes No Yes But				
2.2. Evidence that services are delivered at times convenient to consumer/family.	Yes No Yes But				
2.3. CST team provides crisis coverage	Yes No Yes But				
2.4. Evidence that service frequency aligns with individual consumer needs	Yes No Yes But				
<b>3. Team Functioning</b>					
3.1. Evidence that more than one team member involved with client	Yes No Yes But				
3.2. Evidence of primary CST team member for each client ?????	Yes No Yes But				
<b>4. Services</b>					
4.1. Notes reflect covered CST activities	Yes No Yes But				
4.2. Services are only offered individually	Yes No Yes But				
4.3. Evidence of assistance with Symptom self-monitoring, reduction & management	Yes No Yes But				
4.4. Evidence of counseling and psychotherapy as needed	Yes No Yes But				
4.5. Evidence of active participation & decision making	Yes No Yes But				
4.6. Evidence of support for recovery & resiliency	Yes No Yes But				
4.7. Evidence of assistance to maintain/attain least restrictive environment	Yes No Yes But				
4.8. Evidence of assistance in building family/significant other support skills	Yes No Yes But				

	# Date Span:				
4.9. Evidence of assistance in building natural supports	Yes No Yes But				
4.10. Evidence of assistance in developing strengths & choices	Yes No Yes But				
4.11. Evidence of assistance in Identification of risk factors and relapse prevention plans	Yes No Yes But				
4.12. Evidence of interpersonal, family, and community coping and functional skill development.	Yes No Yes But				
4.13. Evidence of support to develop trauma coping skills	Yes No Yes But				
4.14. Evidence of support and consultation to family and support system	Yes No Yes But				
4.15. Evidence of psychoeducation for family and support system	Yes No Yes But				
4.16. Evidence of support for recovery & resiliency	Yes No Yes But				
<b>5. Discharge/Transition Planning</b>					
5.1. Evidence of discharge/transition goals and planning (including titration of service)	Yes No Yes But				
5.2. CST is only offered with ACT or Community Support Individual during defined transition periods (either into or out of CST services) that are included on treatment plan and DHS-authorized.	Yes No Yes But				
<b>RECORD REVIEW TOTALS</b>					
<b>Record Review Score:</b>				<b>Reviewer</b>	

***PART A: Record Review Notes:***

<b>ACT Provider:</b>	<b>Team Name (if more than 1):</b>
<b>PART B: PROGRAM REVIEW</b>	Page ____ of ____

1. Staffing				
1.1. Fulltime team leader who is QMHP or LPHA	Yes	No	Yes But	
1.2. Minimum of three FTEs total (including team leader) comprise team	Yes	No	Yes But	
1.3. One staff member is a person in recovery or Certified Recovery Support Specialist (preference)	Yes	No	Yes But	
1.4. Staff ratio is 1 FTE for each 18 consumers (excluding psychiatrist and program assistant)	Yes	No	Yes But	
1.5. Team reflects the language, culture, and ethnicity of the population being served. ??? In ACT, not here??	Yes	No	Yes But	
2. Capacity				
2.1. 60% of all team contacts (across all consumers) occur outside of the office	Yes	No	Yes But	
2.2. Staff schedules or other documentation reflect availability	Yes	No	Yes But	
<b>PROGRAM REVIEW TOTALS</b>				
<b>GRAND TOTAL (Record + Program)</b>				

**PART B NOTES:**

**Reviewer:**

**NOTES:**

- 1. Scoring is 10 points for yes, 5 for yes but, and 0 for no
- 2. Recommend looking only at current treatment plan period with exception of comparing to see if treatment plans vary over time.